IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 8958

July 27, 2006

Kelly Spiers, Administrator
Twin Falls Care Center
674 Eastland Drive
Twin Falls, ID 83301

Provider #: 135104

Dear Mr. Spiers:

On **July 14, 2006**, a Recertification survey was conducted at Twin Falls Care Center by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. **This survey found the most serious deficiencies to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached CMS-2567 whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 9, 2006**. Failure to submit an acceptable PoC by **August 9, 2006**, may result in the imposition of civil monetary penalties by **August 29, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **August 18, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 18, 2006**. A change in the seriousness of the deficiencies on **August 18, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 18, 2006** includes the following:

Denial of payment for new admissions effective **October 14, 2006**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 14, 2007**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 14, 2006** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **August 9, 2006**. If your request for informal dispute resolution is received after **August 9, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

Lorene Kayser

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited at the annual recertification survey at your facility. Surveyors conducting the annual survey were: Barb Franek RN, CHON-S Team Coordinator Lorna Bouse, LSW Diane Miller, LCSW Lisa Kaiser, RN Survey Definitions: MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Twin Falls Care Center does not admit that the deficiencies listed on HCFA 2567 exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings all deficiencies, statements, facts, and conclusions that form the basis for each deficiency."	

RECEIVED
AUG 09 2006
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	8-9-6

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, it was determined the facility did not post the most recent results of the Life Safety Code (LSC) survey. This effected 13 of 13 (#1 - 13) sampled residents and all other residents, family members or personal representatives for residents of the facility. The findings include: Idaho Department of Health & Welfare Informational Letter #2003-01, stated "...I believe that when facilities are required at F167 to post a notice and make the most recent survey available to residents, this means the most recent initial survey, or the most recent recertification survey, or the most recent complaint survey. Included in the most recent initial survey and most recent recertification survey is the LSC...With this federal guidance in mind, this agency will begin to check the survey posting with the expectation that the LSC survey will be posted along with the other required surveys. This will begin effective with the date of this letter..." The letter was dated 1/13/03.	F 167	**F167 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** The most recent Life Safety Code Survey (LSC) was posted immediately making it available for examination to all residents and families. **F167 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have the potential to be affected. **F167 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** Life Safety Code Survey results will be posted and available for examination after it is received every year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167	Continued From page 2 During the survey, it was observed at 11:30 am on 7/11/06, that the posted survey book located near the entrance of the facility, did not contain a LSC survey from the Bureau of Facility Standards. On 7/11/06 at approximately 11:45 am, the administrator was asked about the LSC survey. He stated, "I have it here." He pulled the LSC survey, dated 11/21/05, from a manila envelope and agreed to post it in the survey book.	F 167	**F167 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Review quarterly at safety meeting to ensure compliance. **Persons Responsible:** Kelly Spiers, ADMIN Completion Date: Aug 18, 2006 OK, BF, 8/15/06	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225	**F225 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** Residents (#4,9,13) that were affected had these incidents occur in the past and no further investigation could be done. **F225 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents who have accident and incidents have potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4 by: Based on record review, staff interview, facility incident/accident reports, record review and review or abuse prevention policies and procedures, it was determined the facility failed to thoroughly investigate injuries of unknown origin and falls to rule out abuse or neglect. This affected 3 of 16 sample residents (#4, 9 and 13) evaluated for such injuries. Findings include: The facility "Abuse Prevention - Policies and Procedures" (not dated) "Investigation Unexplained Injuries" Chapter 1, page 26, documented: "1. Should a resident be observed with unexplained injuries (including bruises, abrasions, and injuries of an unknown source) ... complete an accident/incident form and record such information in the resident's clinical record. 2. A listing of all personnel, including consultants, contract employees, visitors, family members, etc., who have had contact with the resident during the past 48 hours will be compiled and provided to the person conducting the investigation..." 1. Resident #4 was admitted to the facility on 5/5/05 with diagnoses of dementia, agitation, mitral valve disorder and edema. A fall risk assessment was completed for the resident on 5/5/06 which resulted in a score of 12 (10 or above = High Risk). The resident's quarterly MDS assessment, dated 2/25/06 and his annual MDS, dated 5/10/06, both documented moderate cognitive impairment and that he had fallen in the last 30 days and the last 31- 180 days.	F 225	**F225 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** All nursing staff was in-serviced on proper investigation of accidents and incidents. Accidents and incidents will be reviewed each business day by the interdisciplinary team to determine the cause and need for further investigation. All accidents and incidents will be reviewed weekly for completeness of investigation by the accident and incident team. 225 **F225 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Reviewed weekly at quality assurance meeting until compliant. Person Responsible: Paula Johnson LPN Assistant Director of Nursing, or appointed designee. Completion Date: August 18, 2006 OK, BF, 8/15/06	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 5 The following documentation was contained in the facility incident/accident reports: 10/26/05, (10:00 am)- "...Resident was trying to put his lap buddy back on and slid out of his wheelchair sliding down the wall on his L[eft] side. This was in the DR [dining room] hallway by the TV room...alarm was not turned on & did not sound on lapbuddy [sic]. Res[ident] was wet d/t [due to] urine..." The facility determined the lap buddy alarm was not turned on. However, there was no indication that staff were interviewed to determine when the resident had last been toileted. Recommendations included, "...monitor resident for agitation- res has hx [history] of needing to go to the bathroom when he's acting agitated..." There was no indication that staff determined if he was having any behavioral symptoms of agitation. The report did not indicate why the resident was putting the lap buddy back on. (Had he removed it?) 11/11/05, (9:00 pm)- "...Skin tear R [right] hand...1 cm...Res[ident] had successful fall from hi-lo bed onto mat/pad on floor..." There was no indication that staff had been asked when the resident last received care and what his condition was at that time. There was no investigation that determined if the resident was agitated or had any increased confusion when he fell. 11/17/05, (2:50 pm)- "...[No] injury...Res in TV room sitting in w/c [wheel chair]. He removed his lap buddy, sounding alarm & stood up [without] assistance. Nrg [Nursing] rushed to res but he fell before help received [sic]..." There was no indication what staff were available to supervise	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 6	F 225		

residents in the TV room. This room was across from the nurses' station. (The hall divided the nurse station and the TV room). The report did not say if the nursing staff was in the the nurses' station when they witnessed the fall. There was no indication of how many other residents were in the same area.

11/21/05, (2:10 pm)- " [No] injury...Res found by CNA [name] on the floor @ [at] end of 300 hall under Merri Walker, foot caught in strap-poss[ibly] trying to crawl out of Merri Walker. Walker was upright and functioning..." There was no indication of when the resident was last observed or received care from staff. A written statement from staff (discipline not indicated) contained the following documentation: "I [name] was told that resident was in another residents [sic] room. I went down the hallway and found resident on the floor. The Merrywalker [sic] was hooked up and residents [sic] foot was wrapped on the strap. The nurse came and helped me get him up." There was no indication the facility had attempted to determine if an altercation had occurred when resident #4 had intruded into another resident's room. This could have contributed to his attempt to climb from his Merri Walker. There were no resident interviews documented. It was not determined when he had last received care from staff.

11/26/05, (5:55 pm)- "...abrasion R[ight] shoulder, bump to head...Res was in the assisted dining room, sitting in a regular chair. While staff serving trays, [resident #4] stood up & fell...hitting right elbow then the back of his head 5 cm edematous area skin intact..." The report did not indicate how many staff were present during the fall or if any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 7 staff were near the resident when he got up unassisted. 12/5/05, (5:00 pm)- "[No] injury...Res climbed out of merri-walker [sic], did not fall & did not receive an injury...Resident in dining room in Merry Walker [sic] found on hands and knees outside of Merry Walker. CNA's reported he did not fall extended leg across strap and crawled out. [No] injury alert to person..." It could not be determined how the facility knew the resident did not fall. Three statements were taken but the resident was already on the floor when he was first observed by the witnesses who documented the statements. 12/11/05, (4:00 am)- "Abrasion to L[eft] knee...Heard alarm- found resident [with] feet on mat beside bed [and] L buttock & L hip on floor & head & L shoulder on Merrywalker [sic]. Denied hitting head & pain...resident taken to toilet [with] assist 2 persons- was incontinent of BM..." There was no interview of staff to determine when the resident was last observed or toileted. 4/18/06, (10:30 am)- "...Nursing student reported res was sitting on floor in room merrywalker [sic] was in front of res, bar was unlatched & open res alert per usual, [no] injury noted...He unlatched the merri-walker [sic] & got out, attempted to get self into bed, but fell. He c/o [complains of] some knee pain, but [no] injuries present..." A written statement documented that the resident had told staff he was trying to get to bed. There was no indication the facility determined how long the resident had been up and when he last was observed by staff or provided care.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 8 2. Resident #9 was admitted on 4/6/04 with diagnoses that included Parkinson's disease, diabetes and congestive heart failure. The resident's quarterly MDS, dated 5/18/06, documented moderate cognitive impairment and no falls. The following documentation was contained in the facility incident/accident reports: 1/10/06, (11:30 pm)- "... [No] injury... Res attempting to toilet self during night & didn't quite make it all the way to bathroom & set down on floor to prevent falling & prevent injury..." This information was obtained by resident interview as the fall was not witnessed. Staff found the resident on the floor. There was no documentation of interviewing the resident regarding why she felt she needed to self toilet. It had not been determined if her call light had been available to her or when staff had last checked on her. 3/18/06, (10:00 pm)- "...Pt [atient] presents indented area to upper Rt [right] thigh area expands outer side of Rt thigh. Has Lt [light] green bruise starting to area. Pt is in pain during movement of Rt thigh..." A written statement from staff documented, "Checked in on [resident #9] before shift change. Upon removing her blankets I noticed an indention [sic] on her right lateral femur. When I moved her leg to see if she was dry, she expressed pain. A small amount of pain is usual for this patient but the way she yelled when I moved her leg concerned me so I alerted my nurse at once." The form for administrative review documented, "Not due to injury." There	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 9	F 225		

was no way for the facility to know this at the onset of the injury. There was no evidence anyone spoke with the resident about what may have happened. There was no indication that other staff had been interviewed. The form documented the resident would see a doctor on 3/22/06. Review of the her physician's notes, dated 6/28/06, confirmed she had seen a specialist who reported a torn muscle. The resident had a diagnosis of muscle atrophy. There was no cause for the injury documented in the physician notes.

3. Resident #13 was admitted to the facility on 3/13/05 with diagnoses of Alzheimer's disease, esophogeal reflux, vision loss, constipation, anxiety, psychosis, general pain, Parkinson's disease, after care for hip fracture and behavioral symptoms.

The resident's quarterly MDS, dated 5/17/06, documented she was severely cognitively impaired and needed total assistance for transfers. She had not had a recent fall.

The following documentation was contained in the facility incident/accident reports:

4/17/06, [7:35 am]- "... Scratch to face ... Resident was found to have a 3/6 cm scratch to R[ight] [lower] cheek. Unknown origin. Looked old when found ...CNA stated it wasn't there Saturday on day shift." (The prior Saturday would have been the 15th). It was not documented any staff on Sunday or other prior shifts were interviewed. The report directed staff to keep the resident's nails trimmed and clean. However, there was no documentation of the condition of her nails when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 10	F 225		

the injury was found. The resident had behavioral symptoms and had engaged in resident to resident altercations. (Determined by facility I&A documentation on 5/30/06 and reports to the State agency). It would have been important for the facility to rule this out as a cause for the scratch.

4/23/06, (3:45 pm)- "...Skin tear R[ight] elbow ... found to have a skin tear present to R elbow when staff getting this res up for dinner. Her geri-arms were not on res (in bed) when skin tear found. Probably occurred while placing res into bed for nap." There was no indication that the prior shift staff were interviewed to determine if there was an incident when the resident was transferred to bed for a nap. The only statements documented from staff were from the staff who found the skin tear or were there when it was found.

5/5/06, (3:10 pm)- "...Bruise L[eft] arm ... Res found to have a bruise to LFA [left fore arm]- probably occurred d/t bumping it on 1/2 SR [side rail], while in bed..." There was no indication interviews to rule out abuse or neglect were conducted with staff.

5/19/06, (6:30 am)- " ...Skin tear to LFA ... 6 cm x 1/2 cm- Bumped arm on side rail where rails meet top rail..." On another part of the form documentation indicated this was the "probable cause." There was one staff statement documented, "I [name] was getting -[resident #13] dressed to get out of bed. I rolled her on her L side then went to roll her to her R side to stand up and noticed the skin tear..." The final conclusion was that the resident probably bumped her arm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 11 on the side rail. There was no indication if staff felt this happened while she was getting dressed. There was no indication if the nursing staff could tell that the wound was fresh or may have happened with prior cares. 6/30/06, (2:50 pm)- "... Skin tear RFA [right fore arm] ... Resident cognitively unaware of how incident occurred- staff states while doing cares they observed dried blood & skin tear had already happened. There was no documentation as to the condition of the resident's nails, if she had geri sleeves on or if the side rail padding was in place. The administrator was interviewed on 7/13/06 at 11:10 am regarding facility abuse policies and procedures. He indicated all injuries of unknown origin were investigated. Although the faciltiy abuse policy indicated persons who had contact with the resident in the last 48 hours were to be identified, this was not done. This was to be completed for purposes of identifing potential interviews of persons who had contact with the resident in the 48 hour time frame. The facility failed to thoroughly investigate to rule out abuse and neglect for the above residents.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff and resident interviews, it was determined the facility did not ensure 2 of 13 sample residents (#'s 1 and 9) were provided care which enhanced their dignity. Residents were not provided with personal hygiene care to present a dignified appearance.The findings include: 1. Resident #1 was admitted to the facility on 08/31/04 with diagnoses including osteoporosis, back lumbago, hypothyroidism, tobacco use and anxiety nos [not otherwise specified]. The significant change MDS, dated 4/20/06, documented that resident #1 had problems making decisions regarding tasks of daily life. It indicated she was severely cognitively impaired and required extensive physical assistance of one staff member for personal hygiene. The care plan dated 4/18/06, under the problem area 'Self Care Deficit' identified one of the approaches as, "Assist resident #1 with bathing 2 times a week as scheduled with shampoo, facial shave, and nail care." The Record of Activities of Daily Living documented that resident #1 had not been provided with removal of facial hairs since 3/6/06.	F 241	**F241 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** Resident (#'s1, and 9) was assisted with personal care including facial shaving and nail care. **F241 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have potential to be affected. **F241 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** All staff will be in-serviced on personal grooming of residents. With a focus on how it affects the resident's dignity. In addition, an in-service for all licensed staff will be held to check for grooming issues with the weekly skin checks. Spa personnel or appointed designee will have an established list of residents to audit for grooming issues daily.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 13 The resident was observed on 7/11/06 at 8:05 am, 12:45 pm; on 7/12/06 at 6:10 am and 8:10 am, sitting in her wheelchair in the dining room. The resident had long hair on her chin. The hairs were approximately 1/2 inch in length. Additionally, resident #1's finger nail polish was chipped. A resident interview was conducted on 7/11/06 with resident #1 and she was obviously embarrassed by her finger nails. She covered her hands and looked down at her lap while shaking her head no. On 7/11/06 at approximately 10:15 am, a staff interview was conducted with the DON regarding resident #1's long facial hair. She stated that she wasn't sure how often that staff provided cares to resident #1 to remove her facial hairs and finger nails. When shown the Record of Activities of Daily Living the DNS stated, "It is obvious that the facility is having problems with staff not documenting cares that they are providing. I will see that a CNA immediately provides cares to resident #1 regarding her long facial hairs and finger nails." Resident #1 was observed on 7/13/06 at 10:00 am and she no longer had long facial hairs and her nails were nicely groomed and polished. The facility had not ensured that the resident's hygiene was complete to present her with a dignified appearance. 2. Resident #9 was admitted to the facility on 4/6/04 with diagnoses of Parkinson's disease,	F 241	**F241 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Audits will be monitored by DNS for completion. Results will be review weekly at quality assurance committee meeting until resolved. Following compliance audits will follow quarterly, and as needed. Person Responsible: Melodie Jensen, RN DON Beth Farley, CNA SPA Supervisor, or Appointed Designee. Completion Date: August 18, 2006 OK, BF. 8/14/06	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 14 diabetes and congestive heart failure. The resident's most current quarterly MDS, dated 5/8/06, documented she was moderately cognitively impaired and needed total assistance for her hygiene needs. The resident was observed while receiving ADL care on 7/12/06 at 7:38 am. The resident was sitting in her wheel chair in front of the sink in her room. She was washing her face with a wash cloth that staff had provided. She had long chin hairs. Staff did not offer to shave the resident, who then left the room and was taken to the dining room for breakfast. The resident was dependent on staff to remove the chin hairs promote her dignity related to hygiene.	F 241	**F246 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** Residents (#'s 2 and 3) where assisted up for breakfast and with morning activities of daily living. Call lights where placed with in reach immediately.	
F 246 SS=D	483.15(e)(1) ACCOMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and record review, it was determined the facility did not accommodate the needs of the residents. Call lights were not easily accessible for 2 of 13 sample residents (#2 & 3). Findings include: 1. Resident #2 was originally admitted to the	F 246	**F246 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 15 facility on 7/25/01 and readmitted on 12/29/03 with diagnoses of status post cerebral vascular accident and Alzheimer dementia. The care plan dated 1/21/05 indicated the resident had been identified with the problem of self care deficit related to the cerebral vascular accident. An approach to the problem was to place the call light within reach. On 7/12/06 at 6:20 am, 7:00 am, 7:25 am, and at 7:45 am, the resident was observed to be asleep in the bed. The call light was on the floor and not within reach of the resident. 2. Resident #3 was originally admitted to the facility on 10/21/98 and readmitted on 4/02/99 with diagnoses of status post fractured left hip, dementia and arthritis. The care plan dated 11/29/04 indicated the resident had been identified with the problem of a self care deficit related to disease processes including the arthritis and dementia. An approach to the problem stated, "Remind [resident] has to use call light periodically and make sure call light is within reach. [Resident] uses a special call light that goes on with light touch due to the contractures in her hand." On 7/12/06 at 6:25 am, 6:35 am, 6:55 am, 7:00 am, and 7:25 am, the resident was observed to be asleep in bed. The special call light was resting on the wheelchair seat. The wheelchair was parked near the foot of the bed and not within reach of the resident.	F 246	**F246 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** In-service all staff regarding placement of call lights. Emphasizing that call lights must be within the reach of the resident. The appointed designee will do random audits of call light placement. These audits will be done daily for four weeks, or until compliant. After compliance it will be done as needed. **F246 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The issue will be reviewed weekly at quality assurance meeting until resolved. Person Responsible: Melodie Jensen, RN DNS, or appointed designee. Completion Date: Aug 18, 2006 OK, BF, 8/15/06	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review it was determined the facility did not comprehensively assess 2 of 13 sampled residents (#4 & 1) for functional urinary	F 272	**F272 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** Resident (#1) a new smoking evaluation was completed by Resident Services Coordinator and the Occupational Therapist. The smoking care plan was also updated. Resident (#4) a new seven-day assessment to establish a voiding pattern was completed, and a new individualized toileting schedule was implemented. **F272 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents who smoke have the potential to be affected. All residents who need assistance with toileting have potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 17 continence and smoking safety. Findings include: Resident #4 was admitted to the facility on 5/5/05 with diagnoses of dementia, agitation, mitral valve disorder and edema. The facility started a "Bowel and Bladder 7-Day Assessment" on 5/5/05. The assessment form required hourly documentation for 24 hours for each of the 7 days. The assessment was initiated on 5/5/06 at 3:00 pm and indicated the resident was continent of bladder at 3:00 pm, 5:00 pm, 8:00 pm and 11:00 pm. The assessment did not contain consistent documentation for the facility to establish a voiding pattern. On 5/6 there was a 4 hour and 3 hour gap in documentation. On 5/7 there was no documentation from 2:00 pm to 11:00 pm. On 5/8 there was no documentation from 12:00 am to 6:00 am and two hour gaps for additional times that day. On 5/9 there was no documentation from 2:00 pm to 11:00 pm. There was no documentation completed for days 5/10 and 5/11/05. The assessment was not meaningful and only established that the resident had been continent when they did document his status. On 5/9/05 an "Assessment for Bowel or Bladder Retraining" coded the resident a 19 (scores between 21-15 = good candidate for individualized training). This resulted in a generic care plan for toileting. The approach dated 5/19/05, documented, "Toilet upon rising, before and after meals, at HS [bed time] and during Night rounds and PRN [as needed]. Avoid leaving resident alone on toilet or commode." The resident's most recent annual MDS	F 272	**F272 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** In-service all licenses staff on the need to have complete assessment documentation prior to developing a plan of care. To ensure completeness and accuracy the Director of Nursing, or designee will audit 10% of the weekly assessments. The audit will follow the MDS assessment calendar and which will include new admits. **F272 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Review weekly in quality assurance meeting until compliant with the issue. After compliance it will be reviewed quarterly, and as needed. Person Responsible: Melodie Jensen, RN DNS Completion Date: August 18, 2006 OK. BF 8/14/06	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 18	F 272		

assessment, dated 5/10/06, documented that he was moderately cognitively impaired, needed extensive assistance of one staff for toileting and was totally incontinent of bowel and bladder. A RAP triggered for urinary incontinence and documented, "[Resident #4] has been incontinent of urine and does require up to extensive assistance with toileting. Has DX [diagnosis] of dementia and is not always aware of toileting needs. Will proceed to care plan for routine assistance with toileting..." An additional bowel and bladder retraining assessment, dated 5/18/06, documented a score of 9 (14-7 = candidate for toileting schedule (timed voiding). In addition, documentation included, "Not always cognitively aware of toileting needs. Inc[ontinent] of bowel & bladder. Requires extensive assist for toileting needs. Staff to toilet q [every hour] during day while awake & prn [as needed] during NOC's [night time]." There was no void pattern established for this assessment.

The resident's care plan was revised on 10/26/05 due to a fall on that day. (Documented in care plan). An approach was added, "Toilet resident more frequently [every] 1-2 hrs [hours] while awake & prn." According to the quarterly MDS assessment, dated 9/1/05, the resident had already experienced a decline in cognition and continence (coded as frequently incontinent).

The resident was observed on 7/11/06 at 2:45 pm, using a Merri Walker to ambulate. Two staff were with him by his door. No offer to use the toilet was made by staff. He went into his room and opened the bathroom door. He put the light on and removed the bar enclosing the Merri Walker. He then self toileted. The resident was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 19 observed going to the bathroom independently while using his Merri Walker on 7/12 at 6:38 am and again at 11:00 am. On 7/13/06 at 9:35 am, staff including the DON, ADON [Assist DON] and the MDS LN met with the surveyor. They provided the original 7 day assessment from the resident's admission (see above). They did not comment on the lack of an individualized toilet program being developed for the resident. However, they did agree that many of the resident's falls had revolved around his toileting needs. The facility responded to the resident's needs for individualized toileting based on falls that were related to toileting needs. (Please refer to F324 as it relates to findings regarding prevention of falls). The resident had already experienced a decline and the facility had not done an indepth comprehensive assessment to determine why this had happened and if he could improve or at least maintain his status. His most recent MDS indicated he was fully incontinent. However, the fact that he was observed initiating toileting independently indicated that he may have benefited from restorative toilet training. The facility had not ruled this out by comprehensively assessing the resident. 2. Resident #1 was admitted to the facility on 08/31/04 with diagnoses including osteoporosis, back lumbago, hypothyroidism, tobacco use and anxiety nos [not otherwise specified]. The significant change MDS dated 4/20/06, documented under short term and long term memory that resident #1 did have problems.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 20 Resident #1 was identified as not having adequate memory recall ability and with problems making decisions regarding tasks of daily life. The care plan dated, 4/20/06, identified the following problem area, "Smoking." Approaches included, "Resident #1 is to leave her cigarettes and lighter at the nurses station. FYI [for your information] she was observed with a lit cigarette in her room, several months ago. Update smoking evaluation quarterly and PRN [as needed] concerns or changes in status." The 'Safe Smoking Evaluation' dated 4/24/06 was not completed entirely. The 'Physical Function' section inquired regarding the following: 1. Resident has no physical limitations that interfere with ability to perform safe smoking technique. Limitation:_____; 2. Therapy assessments for physical limitations. Neither of the questions had the yes or no box checked or anything written in the area on the form. The 'Resident Interview' section was completed except the section inquiring, "Resident understands and agrees to use protective equipment while smoking if indicated?" neither the yes or no box were checked. On 7/12/06 at approximately 10:28 am, a staff interview was conducted with the social services designee regarding resident #1's smoking evaluation form. When the surveyor showed her the form she stated, "Oh my, I forgot to complete all of it. Oh that is a problem for resident #1 as she could not holler if she needed help." She stated that she and the Occupational Therapist would accompany resident #1 out to smoke after the lunch meal on this date and finish completing	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 21 the form. On 7/12/06 at approximately 1:30 pm, the social services designee brought to the surveyor a completed 'Safe Smoking Evaluation' form. Under the 'Physical Functioning' section limitation it stated yes. The yes box was checked for both of the inquiries in the section. Under the 'Resident Interview' section the yes box was checked. The facility failed to adequately assessed resident #1 for safe smoking even though she had previously been found to be smoking in her room.	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278 SS=D	483.20(g) - (j) RESIDENT ASSESSMENT The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review it was determined the facility did not ensure the MDS assessment accurately reflected the resident's bowel continence status for 1 of 13 sample residents (#9) who were reviewed for MDS accuracy. Findings include:	F 278	**F278 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** Resident (#9) a new MDS assessment was completed. **F278 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have the potential to be affected. **F278 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** In-service MDS nurses on proper coding of bowel and bladder continence on the MDS. An appointed designee will randomly audit 10% of the MDS's completed weekly to ensure that bowel and bladder section is accurately coded. Also the interdisciplinary team will review all MDS completed according to the weekly MDS schedule. Ensuring that it reflects the information found on the care card, and bowel and bladder assessment sheet.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 23 Resident #9 was admitted on 4/6/04 with diagnoses that included Parkinson's disease, diabetes and congestive heart failure. The resident went to the hospital for treatment of septicemia. She was readmitted to the facility on 2/9/06. The resident's significant change MDS, dated 2/13/06, documented that she was usually continent of bowel. The next MDS, for a 14 day Medicare assessment dated 2/21/06, documented the resident was totally incontinent of bowel. This was the case for subsequent Medicare assessments and the most current, a quarterly MDS, dated 5/18/06. A bowel and bladder assessment dated 5/18/06, documented, "Is Inc[ontinent] of bowel & bladder. Cognitively not able to make needs known. Requires 2 person assist for toileting needs." The care plan contained and identified problem last revised 5/18/06, which documented, "... at risk for skin alteration due to frequent incontinent of urine..." Approaches included, "Assist to bathroom on a routine basis ... long history of uncontrollable bladder ... change pads when soiled or wet." The current resident care card indicated the resident was continent of bowel and should be toileted every 2 hours. This was not dated and were directional plans used by nurse aides for resident care. Bowel records for May 2006 documented the resident was incontinent of bowel 6 times in 31 days and continent of bowel 5 times. This was during the most recent MDS assessment period of 5/18/06.	F 278	**F278 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Review weekly at quality assurance meeting until compliant. Person Responsible: Melodie Jensen, RN DNS Completion Date: August 18, 2006 OK, BF, 8/15/06	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 24 The resident was observed on 7/11/06 at 10:55 am. She was in her room and in bed when the surveyor walked up to her open door. She called out, "Hey, come here." The surveyor asked her what she needed. She said she needed to go to the bathroom. The surveyor asked an aide to help the resident. The resident's family member and representative was interviewed by telephone on 7/12/06 at 7:10 pm. The family member indicated the resident had been incontinent of urine for a long time but was not fully incontinent of bowel. An interview was conducted with the DON and ADON both present on 7/13/06 at 10:05 am. They both said the resident was toileted and not totally incontinent of bowel as coded on the MDS. The MDS for bowel continence was not recorded accurately.	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279 SS=B	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure the care plans for 9 of 13 (#1, 2, 3, 5, 6, 7, 10, 11 and 12] sampled residents included measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment. Findings include: 1. Resident # 7 was originally admitted to the facility on 11/22/99 and readmitted on 8/31/02 with diagnoses including dementia, hypertension, joint pain, lumbago, psychosis, pulmonary	F 279	**F279 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** Residents (#1,2,3,5,6,7,10,11,12) care plans for these affected residents were review and updated. **F279 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have the potential to be affected. **F279 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** In-service all licensed nursing staff and interdisciplinary team on dating, and timeliness of the care plan requirements. Care plan dates and timetables will be audited each week at care plan meeting according to the MDS assessment schedule.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 26 congestion, glaucoma, atrial fibrillation, hypothyroidism, adjustment reaction prolonged depression and anxiety. The resident's care plan identified the following problems and goals but did not identify a goal or target date or indicate if the problem was ongoing or resolved: *2/27/06 Problem: "Res[ident] fell while getting self OOB [out of bed] - hit head on nightstand - bump to head." Goal: "[No] injuries related to falls." *3/15/06 Problem: "Abrasion rectal fold" Goal: "Heal [without] complications." *4/25/06 Problem: "Has episodes of pain due to [right] great toe red, resident c/o [complains of] pain upon light palpation to [right] great toe." Goal - "Episodes of pain will be resolved within 1 hour of intervention." *4/20/06 Problem: "This resident bit a staff member on the arm when staff was washing res[ident's] hands after dinner." Goal: "Res will not have further similar incidents." *5/17/06 Problem: "Fall. 5/14/06 from hi-low bed. Redness to back." Goal: " Resident will be free of complications related to fall." *5/13/06 Problem: "Resident found sitting on floor @ bedside." Goal: "[No] injuries R/T [related to] falls." 2. Resident # 10 was originally admitted to the facility on 12/11/03 and readmitted on 2/9/06 with	F 279	**F279 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Review weekly at quality assurance meeting until compliant. Person Responsible: Melodie Jensen, RN DNS Lisa Schultz, RN MDS Coordinator Completion Date: August 18,2006 OK, BF, 8/15/06	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 27 diagnoses including femur fracture, diabetes mellitus, hypertension, asthma, late-effect CVA [Cerebral Vascular Accident], dysphagia, osteoporosis, congestive heart failure, history of falls, and adjustment reaction prolonged depression. The resident's care plan identified the following problems and goals but did not identify a goal or target date or indicate if the problem was ongoing or resolved: *2/8/06 Problem: "Risk for repeat CVA as resident has recently had a CVA." Goal: "No repeat CVA." *2/8/06 Problem: "Risk for shortness of breath as resident has pneumonia. Hx [history]." Goal: "No shortness of breath X [times] [blank] days." *2/8/06 Problem: "Resident experiences labile hypertension." Goal: "Resident will maintain a blood pressure of systolic less than 140 and diastolic less than 90 for the next 90 days." *2/8/06 Problem: "Has episodes of pain due to: fractured hip s/p [status post] arthroplasty." Goal: "Episodes of pain will be resolved within 1 hour of intervention." *2/8/06 Problem: "Risk for pain due to bone fracture: - fx [fractured] hip." Goal: "Pain will be relieved within 1 hour of interventions." *2/8/06 Problem: "Resident has diagnosis of diabetes mellitus." Goal: "Resident will not present signs or symptoms of hyperglycemia or hypoglycemia for the next 90 days."	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 28 *5/31/06 Problem: "Fall. from w/c [wheel chair] to floor on 5/29/06, while reaching down for a sock." Goal: "Resident will be free of complications related to fall." *2/14/06 Problem: "Need for daily RNA [Restorative Nursing Aide] program." Goal: "1) Will transfer [without] pain in [left] hip during ADLs to reduce risk of falls 2) Will feed him-self independently [after]set up [with] meals [with] min[imal] verbal cues to finish meals 3) Pt. [patient] will be eating at least 75% of meal." 3. Resident # 12 was admitted on 4/18/06 with diagnoses including fractured left femur, polymyalgia, hypokalemia, atrial fibrillation, depressive disorder, hypothyroidism, and peptic ulcer. The resident's care plan identified the following problems and goals but did not identify a goal or target date or indicate if the problem was ongoing or resolved: *4/18/06 Problem: "Risk for side effects from antidepression medication. Zoloft." Goal: "Will not have any side effects from medication." *4/18/06 Problem: "Has episodes of being anxious as demonstrated by: [blank]." Goal: "Acute episodes of anxiety will be limited to [blank] minutes." *4/18/06 Problem: "Fractured hip." Goal: "Resident will remain free of infection at surgical site, keep joint aligned and prevent unnecessary mobility x 30 days."	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 29 *4/18/06 Problem: "Resident experiences labile hypertension." Goal: "Resident will maintain a blood pressure of systolic less than 140 and diastolic less than 90 for the next 90 days." *4/18/06 Problem: "Risk for irregular pulse and chest pains secondary to history of heart disease. at[rial] fib[rillation]." Goal: "Will not have chest pains. Pulse will remain between: [blank]." *4/18/06 Problem: "Has episodes of pain due to: - PUD [peptic ulcer disease] - chronic back pain - hip fx [fracture] - polymyalgia Rheumatica." Goal: "Episodes of pain will be resolved within 1 hour of intervention." *4/18/06 Problem: "[Left] hip surgery staples & pressure relief." Goal: "heal [without] complications." *4/18/06 Problem: "2. Bruising." Goal: "Resolve." *4/18/06 Problem: "3. Callused - cracked [left] foot." Goal: "Resolve." *5/3/06 Problem: "Episodes of insomnia as manifested by: Ambien." Goal: "Will sleep 6-8 house [sic] per night." An interview was conducted with the DON, the Administrator, and an LN on 7/13/06 at 8:21 am regarding the missing goal dates on resident's care plans. The DON acknowledged that the goals on the care plans should include a target or goal date. She stated, "They should be dating all of that...yes, and resolving..."	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 30	F 279		

4. Resident #2 was originally admitted to the facility on 7/25/01 and readmitted on 12/29/03 with diagnoses of status post cerebral vascular accident and Alzheimer dementia.

a. The care plan dated 3/31/06, indicated the facility had identified a problem of mood decline and behaviors. The original onset date was 3/31/06 with a target date of 6/29/06. The next onset date was 6/21/06 with a target date of 9/21/06.

The short term goal for the problem of mood decline and behaviors stated, "[resident] will show...decrease in behaviors and coming to dining room for meals and accepting medications and needed cares...will not have adverse side effects fro[m] psychoactive medications. The beginning goal date was 3/31/06 with a target date of 6/29/06. The short term goal had not been updated.

b. The care plan with a date of 1/21/05 (the current care plan had different dates for some sections of the care plan), indicated the resident had been identified as having a problem with falls. The problem was dated 12/20/05.

The short term goal stated, "No injuries d/t [due to] any further falls." The goal dates were written as "12-18-5 - 3-18-5 [sic]." The goal date had not been updated for over a year.

5. Similar findings for residents #1, 3, 5, 6, and 11.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 31 On 7/13/06 the DON was interviewed about the care plans at 8:30 am. The DON concurred that some of the goal dates had not been updated. The DON stated, "someone else does those sections of the care plans." The DON explained that different individuals were assigned different sections of the care plan to complete and update.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility did not ensure residents' care plans were reviewed and revised to reflect	F 280	**F280 What corrective action(s) will be accomplished for those residents found to have been effected by the deficient practice;** The affected residents (#'s 4,6,7,9,10 and 12) had their care plans reviewed and updated by interdisciplinary team. **F280 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;** All residents have the potential to be affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 32 current treatments and approaches. This affected 6 of 13 sample residents (#4, 6, 7, 9, 10 and 12). Findings include: 1. Resident # 7 was originally admitted to the facility on 11/22/99 and readmitted on 8/31/02 with diagnoses including dementia, hypertension, joint pain, lumbago, psychosis, pulmonary congestion, glaucoma, atrial fibrillation, hypothyroidism, adjustment reaction prolonged depression and anxiety. The resident's most recent MDS, dated 4/26/06, documented the resident required extensive physical assistance of one staff member for eating. The resident's care plan, dated 1/19/06, documented the resident had a self care deficit and one approach in reference to eating was, "(4) Requires up to supervision for eating. Needs verbal cues to stay on task." The resident's care plan was not revised to accurately reflect the resident's need for assistance to eat. 2. Resident # 10 was originally admitted to the facility on 12/11/03 and readmitted on 2/9/06 with diagnoses including femur fracture, diabetes mellitus, hypertension, asthma, late-effect CVA [Cerebral Vascular Accident], dysphagia, osteoporosis, congestive heart failure, history of falls, and adjustment reaction prolonged depression. The resident's most recent MDS, dated 5/8/06, documented the resident required extensive	F 280	**F280 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** In-service of all licensed staff and interdisciplinary team on accuracy of care plans, to include temporary and permanent care plans and the importance of reflecting the individual resident status. Care plans will be reviewed for accuracy by interdisciplinary team every week according to the MDS schedule. The DNS, or designee to ensure accuracy will do random audits of all care plans. **F280 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** Review weekly in quality assurance meeting until compliant. After compliance will audit quarterly and as needed. Person Responsible: Melodie Jensen, RN DNS Lisa Schultz, RN MDS Coordinator Completion Date: August 18, 2006 OK, BF, 8/15/06	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 33	F 280		

physical assistance of one staff member for bed mobility, transferring, locomotion on the unit, dressing, toileting, and personal hygiene. The resident required physical help with bathing as well. The MDS documented the resident had some difficulty expressing information as well as understanding others and was taking an antidepressant.

Documentation in the resident's chart revealed the resident's primary language was not English.

The care plan in the resident's record on 7/10 and 7/11/06, was dated 3/01/2006, and did not address the following: the assistance needed to complete ADLs and the resident's use of an antidepressant and underlying factors. The care plan present in the resident's chart documented a problem of: "In-Ability to understand others: [resident #10] sometimes understands & responds adequately to simple/direct communication." The short-term goal for this problem was: "(1) [Resident #10] to attend activities 1/2 [one to 2] times weekly until next review." The approaches listed included interventions for effective communication as well as interventions pertaining to activities. The target date for the problem was 5/30/06.

An interview was conducted with the MDS Coordinator on 7/11/06 at 1:47 pm regarding the resident's care plan and the missing information. The MDS Coordinator stated, "It looks like the computer-generated care plan hasn't made it to the chart yet...It's done...it's in the computer..." The MDS Coordinator returned with a computer-generated copy of the resident's care plan on 7/11/06 at 1:59 pm and stated, "[LN's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 34	F 280		

name] and I just printed out what we had on the computer...I just dated it for today..." The care plan presented to the surveyor at that time was complete and addressed the above-mentioned issues.

3. Resident # 12 was admitted on 4/18/06 with diagnoses including fractured left femur, polymyalgia, hypokalemia, atrial fibrillation, depressive disorder, hypothyroidism, and peptic ulcer.

The resident's most recent MDS, dated 6/06/06, documented she required extensive physical assistance of one staff for bed mobility, locomotion on the unit, and dressing. The resident required total physical assistance of two staff for transferring, toileting, and personal hygiene and required physical assistance for bathing. The resident was occasionally incontinent of bowel and bladder and had impaired vision.

The care plan present in the resident's chart on 7/12 and 7/13/06, did not address the assistance required to complete ADLs, the bowel and bladder incontinence, or the resident's impaired vision.

The DON was interviewed on 7/13/06 at approximately 8:33 regarding incomplete care plans in resident's charts. She stated there was a "Cardex" on each of the halls with instructions for the CNAs. She said the "Cardex" was initiated upon a resident's admission and "I update it with new orders, etc..."

The care plans were the road map which guided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 35	F 280		

the healthcare team to provide appropriate cares to the resident. As the residents' needs changed, it was important to review and revise the care plans.

4. Resident #6 was admitted to the facility on 3/31/06 with diagnoses including multiple myeloma, hypothyroidism, atrial fibrillation and glaucoma.

The quarterly MDS dated 6/10/06, identified resident #6 as having modified independence-some difficulty in new situations only under cognitive skills for daily decision making. The MDS documented that resident #6 was able to make himself understood to others and that he understood others. His vision was documented as adequate-sees fine detail, including regular print in newspapers/books.

The temporary care plan dated 3/31/06, identified a problem area for resident #6 as vision. The approaches for resident #6 included: "use short phrases and questions that require yes or no answers. Use gestures as necessary; Reassurance and patience when resident attempts to communicate; involve in activities that don't depend on resident's ability to communicate or understand."

On 7/13/06 at approximately 8:30 am, a staff interview was conducted with the DNS regarding the vision care plan for resident #6. She stated, "That care plan is inappropriate for resident #6. He most definitely has no problems with his cognitive and communication skills."

The facilty failed to individualize the care plan for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135104	A. BUILDING _____ B. WING _____	07/14/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN FALLS CARE CTR	674 EASTLAND DR TWIN FALLS, ID 83301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 36 resident #6 so that it was appropriate for his level of functioning. 5. Resident #4 was admitted to the facility on 5/5/05 with diagnoses of dementia, agitation, mitral valve disorder and edema. The facility started a "Bowel and Bladder 7-Day Assessment" on 5/5/05. The assessment form required hourly documentation for 24 hours for each of the 7 days. The assessment was initiated on 5/5/06 at 3:00 pm and indicated the resident was continent of bladder at 3:00 pm, 5:00 pm, 8:00 pm and 11:00 pm. The assessment did not contain consistent documentation for the facility to establish a voiding pattern. On 5/6 there was a 4 hour and 3 hour gap in documentation. On 5/7 there was no documentation from 2:00 pm to 11:00 pm. On 5/8 there was no documentation from 12:00 am to 6:00 am and two hour gaps for additional times that day. On 5/9 there was no documentation from 2:00 pm to 11:00 pm. There was no documentation completed for days 5/10 and 5/11/05. The assessment was not meaningful and only established that the resident had been continent when they did document his status. On 5/9/05 an "Assessment for Bowel or Bladder Retraining" coded the resident a 19 (scores between 21-15 = good candidate for individualized training). This resulted in a generic care plan for toileting. The approach dated 5/19/05, documented, "Toilet upon rising, before and after meals, at HS [bed time] and during Night rounds and PRN [as needed]. Avoid leaving resident alone on toilet or commode." The resident did not have a care plan	F 280		